Adult History Form

Patient Name _____ Date of Birth _____

Occupation _____ Referring Physician _____

Address _____

Primary Concern _____

1. How would you best describe your hearing? More than one may apply.
   - ☐ Hearing is fine with no concerns
   - ☐ Able to hear but not clearly
   - ☐ Difficulty hearing in noisy environments
   - ☐ Difficulty hearing from a distance
   - ☐ Difficulty hearing in group situations
   - ☐ Unable to hear

2. Do you feel that your hearing is better in one ear versus the other? ☐ Yes ☐ No
   If yes, which ear is better? ☐ Right ☐ Left

3. Have you previously had a diagnostic hearing test? ☐ Yes ☐ No
   If yes, how long? _____ Results? _____

4. Have hearing aids ever been recommended? ☐ Yes ☐ No Worn? ☐ Yes ☐ No
   Which ear? ☐ Right ☐ Left ☐ Both
   Any concerns regarding your current hearing aids? _____

5. Do you ever experience noises in either ear (ringing, hissing, buzzing)? ☐ Yes ☐ No
   If yes, describe: _____
   When did the sound begin? _____
   How frequently? ☐ Rarely ☐ Occasionally ☐ Daily ☐ Constantly, sound does not stop
   Where? ☐ Right Ear ☐ Left Ear ☐ Both ☐ Cant tell location

6. Do you have a history of ear infections? ☐ Yes ☐ No
   If yes, when was last infection? _____

7. Have you ever had ear surgery? ☐ Yes ☐ No
   If yes, what surgery? _____

8. Is there a family history of hearing loss? ☐ Yes ☐ No
   If yes, who? _____
   If known, why? _____

9. Have you ever been exposed to loud noise, recently or in the past? ☐ Yes ☐ No
   - ☐ Firearms
   - ☐ Factory work
   - ☐ Military equipment
   - ☐ Power tools
   - ☐ Music
   - ☐ Farm equipment
   - ☐ Explosions
   - ☐ Heavy equipment
   - ☐ Motorcycles/ recreational vehicles
   - ☐ Other: _____

Please check (√) if you have experienced any of the following:

- ☐ Excessive ear wax
- ☐ Ear drainage/bleeding
- ☐ Swimmer's Ear
- ☐ Ear pressure/fullness
- ☐ Popping sensation in the ear
- ☐ Ear pain
- ☐ Fluctuating hearing loss
- ☐ Fluid behind the eardrum
- ☐ Dizziness/Vertigo
- ☐ Sensitivity to loud noises

Please check (√) if you have been diagnosed with any of the following:

- ☐ Otosclerosis
- ☐ Cholesteatoma
- ☐ Sudden hearing loss
- ☐ Labyrinthitis
- ☐ Meniere's disease
- ☐ Barotrauma
- ☐ Permanent hearing loss
- ☐ Ossicular dislocation/fixation
- ☐ Acoustic neuroma
- ☐ Bell's palsy

Medical History

Have you ever used tobacco products of any kind? ☐ Yes ☐ No

How many alcoholic drinks/week do you consume? _____

Please check (√) if you have experienced any of the following:

- ☐ Heart disease
- ☐ Mumps
- ☐ Kidney or renal problems
- ☐ Stroke/TIA
- ☐ Meningitis
- ☐ Chronic sinus infections
- ☐ Diabetes
- ☐ Measles
- ☐ Environmental allergies
- ☐ High blood pressure
- ☐ Scarlet fever
- ☐ Cancer
- ☐ Hypothyroidism
- ☐ HIV/AIDS
- ☐ Radiation/chemotherapy
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Long term IV antibiotics
- ☐ Mental illness
- ☐ Visual Problems
- ☐ Head trauma
- ☐ Depression or anxiety
- ☐ Hepatitis A, B or C
- ☐ Loss of Consciousness
- ☐ Migraines
- ☐ Liver Problems
- ☐ Exposure to chemicals/solvents

Please list your current prescriptions:

Medication	Reason

** If needed, please list additional medications on separate piece of paper.*

_____ _____

Signature of person completing history Date

_____

Relationship to patient